Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JAMES WEISS MD
3100 TIMMONS LANE SUITE 250
HOUSTON TEXAS 77027

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
AMERICAN STATES INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-11-3890-01

MFDR Date Received
July 6, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier refuses to pay full amount due for services rendered, even after request for reconsideration was submitted."

Amount in Dispute: $415.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor is seeking reimbursement for date of service April 28, 2011 in the amount of $1,760.24. The date of service at issue is for an EMG/nerve conduction study at the request of the designated doctor. The bills at issue were paid on July 19, 2011 in the amount of $1,344.63. The services made the basis of this response have been reimbursed in accordance with the Medical Fee Guidelines and no further reimbursement is due."

Response Submitted by: Thornton, Biechlin, Segrato, Reynolds & Guerra, L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 28, 2011	99203, 95861, 95900, 95903, 95904, 95934 and A4556	$415.61	$3.97

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedure for professional medical services provided on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 28, 2011
   - 16 – Claim/service lacks information which is needed for adjudication.
   - 1 – Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge.

   Explanation of benefits dated June 8, 2011
   - 1 – This item was previously submitted and reviewed with notification of decision issued to payor, provider (duplicate invoice.)

Issues

1. Did the requestor submit an updated table of disputed services?
2. Did the requestor bill for services in conflict with NCCI edit?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor submitted a copy of a new table updating the disputed amount of $415.61 and reflecting the payment issued by the insurance carrier of $1,344.63. The requestor seeks reimbursement for CPT codes; 95900, 95934 and A4566 in the amount of $415.61, therefore only these codes will be considered in this audit.
2. The requestor seeks reimbursement for CPT codes 95900, 95934 and A4556 rendered on April 28, 2011.
3. 28 Texas Administrative Code §134.203 states in pertinent part, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
   - NCCI edits were run to identify if the disputed charges contain edit conflicts.
   - Per CCI Guidelines, Procedure Code 95900 has a CCI conflict with Procedure Code 95903. A modifier may be appropriate. The requestor did not append a modifier, therefore, reimbursement is not recommended for CPT code 95900.
   - Per Medicare guidelines procedure code A4556 is an item or service that has no separate payment under the physician fee schedule. Reimbursement is therefore not recommended for HCPCS code A4556.
   - CPT code 95934 did not contain NCCI edit conflicts and will therefore be reviewed according to the applicable guidelines.
4. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting... Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."
   - For every service that is assigned a value by Medicare there is a specific reimbursement amount in the workers' compensation system. The reimbursement will vary depending upon the geographic area where the service is provided. Review of box 32 of the CMS-1500 documents that the services were rendered in Houston, Texas, zip code 77027, the carrier (MAC) locality is Houston; therefore Houston is selected to determine the Medicare reimbursement for the disputed CPT codes.
   - The requestor billed CPT code 95934 in the amount $176.51. The insurance carrier issued payment in the amount of $172.54. The DWC's fee guideline reimbursement is $179.91. The requestor seeks reimbursement in the amount of $3.97, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3.97.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3.97 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		June 14, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.